Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS640HOS	A. BUILDING _____ B. WING _____	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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S 000	Initial Comments This Statement of Deficiencies was generated as the result of a complaint investigation survey conducted at your facility on 03/31/09. The state licensure survey was conducted in accordance with Chapter 449, Hospitals, adopted by the State Board of Health December 11, 1998 last amended September 27, 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following complaints were investigated. Complaint #NV00015976 - Unsubstantiated Complaint #NV00020447 - Unsubstantiated Complaint #NV00019346 - Unsubstantiated Complaint #NV00017091 - Unsubstantiated Complaint #NV00019406 - Substantiated (Tag S0298) Complaint #NV00017509 - Substantiated (Tag S0060) Complaint #NV00020260 - Substantiated (Tag S0154, S0156) Complaint #NV00017192 - Unsubstantiated The following regulatory deficiencies were identified.	S 000		
S 060 SS=D	NAC 449.3152 Quality Improvement 1. The governing body of a hospital shall ensure that the hospital has an effective, comprehensive quality improvement program to evaluate the provision of care to its patients.	S 060		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 060	Continued From page 1 This Regulation is not met as evidenced by: Based on interview, record review and document review the governing body of the facility failed to ensure the hospital had an effective, comprehensive quality improvement program to evaluate the provision of care to its patients. Findings include: The medical records indicated Patient #7 was an 18 year old female gravida 1 (pregnancy) Para 0 (birth) admitted to the facility on 10/16/04 in active labor. The Labor and Delivery Flowsheet documented the following: - 10/16/04 at 9:14 PM, indicated the patient was complaining of contractions every 2 to 3 minutes for the last few hours. An external fetal monitor was placed. The patient was orientated to the room. The mother was at the bedside. - 10/17/04 at 3:00 AM, indicated the patient was awaiting an epidural. - 10/17/04 at 3:10 AM, indicated Physician #4 was present and setting up for an epidural. - 10/17/04 at 3:30 AM, indicated the patient was feeling her legs were heavy and was not feeling her contractions. - 10/17/04 at 4:00 AM, indicated the patient denied any pain. The patient was feeling heaviness in her chest and feeling like she was going to pass out. IV(intravenous) bolused, blood pressure was noted to be lower than normal. Physician # 4 called and notified that epidural syringe had emptied in approximately 30 minute time period. Patient was feeling heaviness in her chest but was breathing well and saturating at 97-100% on room air. Physician #4 spoke with charge nurse. IV bolus in progress. Patient was stable. Fetal heart tones were stable. Pulse = 73,	S 060		

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S 060	Continued From page 2 blood pressure = 117/47, respirations = 20. The facility Risk Management Report dated 10/17/04 at 4:00 AM, indicated Physician #4 did not notice the pump setting for the epidural set at 98 instead of 08. The epidural pump was set incorrectly and the whole syringe infused in about 30 minutes. The patients breathing and oxygen saturation were monitored. The patient was given an IV bolus. The nurse was at bedside for one to one observation for about 2 hours. The Anesthesia Record by Physician #4 dated 10/17/04 indicated the patients epidural syringe rate was incorrectly set. The patient was monitored for adverse effects other than leg and chest heaviness. The Anesthesia Progress Note by Physician #4 dated 10/17/04 at 8:00 AM, included: The patient received her labor epidural around 3:00 AM. About 1 ½ hours after the block Physician #4 was notified the syringe was completely empty. It was determined by the nursing staff that the pump was set at 98 instead of 08, administering the epidural at an increased rate. Physician #4 instructed the nursing staff to stop the epidural until the medication wore off and to expect the patient to experience heavy legs, and some chest heaviness. Physician #4 ordered the use of oxygen as necessary to keep the patients oxygen saturation levels greater than 90%. "Based on the fact that we (Anesthesia) use dilute local anesthetic mixtures, and this unfortunate occurrence has happened before, I felt confident that the patient would remain stable." "The nursing staff states she remained stable throughout the night, with adequate blood pressures, pulse, fetal heat tones and oxygen	S 060		

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S 060	Continued From page 3 saturation, and they were instructed to notify me immediately if the patient's condition deteriorated in any way. Overall there was no adverse outcome to mother or baby in any way what so ever." On 04/01/09 at 8:15 AM, the Vice President of Quality Risk Management confirmed Physician #4's epidural medication error was not reported as a Sentinel Event and was not reviewed by the Quality Assurance Committee or Peer Review Committee. A Root Cause Analysis of the incident was not done. The Vice President of Quality Risk Management indicated the facility's hospital wide Peer Review Process Policy, Performance Improvement Policy and Sentinel Event Policy were not followed in reference to the physician's epidural medication error. The incident should have been reported as a Sentinel Event and reviewed by the Quality Assurance and Peer Review Committees. A Root Cause Analysis should have been completed on the incident. The facility's Peer Review process Policy revised 04/07/04, indicated it was the policy of the facility to utilize a peer review process as defined by the medical staff. Under Procedure: Such activities were inclusive of, but not limited to the following: A. "Aggregate data regarding organizational performance is summarized and presented to the divisions on a quarterly basis." B. "Concerns regarding the performance of an individual practitioner are addressed following the approved algorithm." C. "Utilizing criteria as well as professional expertise, a determination is made whether the standard of care is met or not met." D. "Reviews are filed in each practitioner's quality file for identification of any trends or actions taken	S 060		

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S 060	Continued From page 4 by medical staff leadership." Process: C. "As deemed appropriate, the Division Director, Chief of Staff or the Medical Executive Committee may request a peer review panel to review quality of care concerns. The panel will be composed of not less than three (3) members who meet the "peer definition." This panel will complete their findings within 90 days." The facility's Sentinel Event Policy effective 1998, last revised 12/14/06, defined a Sentinel Event as an unexpected occurrence involving death or serious physical or psychological injury, or the risk there of. Serious injury specifically included loss of limb or function. Risk there of was defined as any process variation for which a recurrence carried a significant chance of serious adverse outcome. The facility's Sentinel Event Procedure included the following: "The facility will identify all sentinel events that have occurred and will conduct a thorough, credible, RCA, (root cause analysis) including an acceptable action plan." The facility's Performance Improvement Plan Policy effective 1996, last revised 10/25/07, included under Medical Staff: "In the event that a problem related process is identified that impacts upon patient outcome or patient safety, interdisciplinary teams will be mobilized or established as deemed necessary. Members will be representative of the medical staff department involved, as well as, nursing and ancillary personnel as required to efficiently address the problem at hand. Results and findings of the medical staff performance improvement activities	S 060		

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S 060	Continued From page 5 will be reported to the Quality Council, Medical Executive Committee and the Board of Trustees." Severity: 2 Scope: 1 Complaint #NV00017509	S 060		
S 154 SS=D	NAC 449.332 Discharge Planning 12. If, during the course of a patient's hospitalization, factors arise that may affect the needs of the patient relating to his continuing care or current discharge plan, the needs of the patient must be reassessed and the plan, if any, must be adjusted accordingly. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to reassess or adjust the discharge plan of a patient when factors arose that affected the needs of the patient relating to his continued care or discharge plan. (Patient # 1) Findings include: The facility History and Physical dated 09/10/08, indicated the patient was a 32 year old male who was transferred to the facility from a nursing home for treatment of persistent seizure episodes. The patient's diagnoses included seizure disorder, possible sepsis, chronic respiratory failure, history of motor vehicle accident with head injury and subsequent encephalopathy, hypertension, and multiple decubitus ulcers with contractures. The Physician Admission Orders dated 09/10/08, included Dilantin 800 mg (milligrams) IVPB loading (intravenous piggy back) followed by Dilantin 100 mg IVPB every 8 hours.	S 154		

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S 154	Continued From page 6 The Nursing Note dated 09/11/08 at 9:00 PM, indicated the patient's right arm IV line was discontinued. The patient's right arm was swollen with blisters on the hand and large blisters on the middle and right finger. The right thumb was purple and there were three draining blisters. The hand was elevated and the nurse called the pharmacist to discuss possible necrosis with Dilantin. The facility Risk Management Report dated 09/12/08 at 2:05 AM, indicated the nurse found the patient's IV on the right hand had infiltrated while IV normal saline was running at 100 ml (milliliters) per hour. The nurse removed the Kerlix that was wrapped around the patients hand and found his hand was blistering; right thumb purplish, whole arm was swollen and bigger than the left arm. The patients pulse was palpable upon checking but the skin was cool to touch. The nurse called and notified the attending physician. No orders were given. Physician #2 came around 11:00 PM and assessed the patients arm. Physician orders were given for an MRI (magnetic resonance imaging) scan and if an MRI scan could not be done to do a CT (computerized tomography) scan of the patients arm and hand. A stat (immediate) X ray was ordered. The right hand x-ray report dated 09/12/08 documented under findings: "Contracted flexed hand without fracture or dislocation. There is subchondral cyst along the base of the fifth metacarpal (finger). Soft tissue swelling seen along the hand dorsally. Moles or skin tags seen in the proximal to the wrist." The right forearm CT Scan report dated 09/12/08,	S 154		

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S 154	Continued From page 7 indicated there was soft tissue edema seen within the distal right forearm, wrist and dorsum of the right hand. The Physicians Progress Note dated 09/12/08, indicated the patients intravenous antibiotic Merrem infiltrated in the patient's right hand and wrist region causing swelling, erythema, soreness and blistering. The Physician Progress Note dated 09/12/08, documented possible contact dermatitis with blister formation to the patients right hand. The Physicians Progress Note dated 09/12/08, documented right hand blisters dorsal surface of the hand with questionable necrosis. The recommendation included a hand surgery consult regarding the patient's right hand. The Surgical Consultation Report by Physician #3 dated 09/12/08, indicated the patient had an intravenous medication infiltration in his right hand 35 to 48 hours ago. The patient was noted to have woody indurations of his arm and blister formation possibly from an intravenous infiltrate of Dilantin or Keppra medication. The patient had symptoms for 1 full day prior to the consultation. The patient was evaluated for compartment syndrome verses necrosis. The impression and plan indicated the patient did not have compartment syndrome. The physician after speaking to an infectious disease physician recommended local wound care to the blisters on the hand, necrosis on the dorsal aspect of the hand. The physician indicated surgical intervention would leave large open wounds which would not be able to be covered. The patient would be better off leaving the blisters and necrosis to heal without any full thickness	S 154		

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S 154	Continued From page 8 exposure to the environment. The Physician Hand Consult Note dated 09/12/08 at 8:30 PM, documented "No active compartment syndrome on physical exam, IV infiltrate-open necrosing tissue, local wound care, may need plastic surgery coverage if necrosis all dorsal skin..." The Physician Transfer Summary dated 09/15/08, indicated the patients discharge diagnoses included right upper extremity hand drug reaction with ischemic skin changes. During the patients hospitalization the patient developed a drug reaction likely caused by intravenous Dilantin or antibiotics that infiltrated. The patients IV line spilled over the skins tissue causing a blister formation on the right hand. The discharge medications orders included Silvadene 1% cream applied to areas of the right hand twice a day. The Physicians Progress Note dated 09/15/08, documented "Hand surgery notes reviewed, May need plastics here. Don't think SNF (skilled nursing facility) can care for iatrogenic (caused by a physician's treatment or procedure) wound there." The Physician Hand Consult Progress Note dated 09/15/08 at 12:30 PM, documented, "Hand inspection, dorsal wounds, blisters, decrease likely infiltrate with dorsal necrosis. Recommend local wound care per plastic surgery. No surgical intervention needed at this time." The Physicians Order dated 09/15/08, indicated wound care evaluation, Physician #7. WST (wound skin therapy) evaluate for wound care. Not suitable for TIF (transfer inter facility)	S 154		

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S 154	Continued From page 9 The Nursing Note dated 09/15/08 at 2:00 PM, documented "Note several small open ulcerations and 4 larger ulcerations on right hand/wrist area. Several blisters are still present. Note large amount of serosang DRNG (drainage). Note moderate amount of blackened slough and necrotic tissue. Cleansed with normal saline soaked gauze. Applied Silvadene cream, then telfa, then wrapped with Kerlix." The Physician Order dated 09/16/08, documented respiratory stable for transfer inter facility if SNF (skilled nursing facility) was able to care for right hand. The Case Management Note dated 09/14/08 at 11:39 AM, documented "Received referral for re-evaluation for the skilled nursing facility. Patient unable to sign choice form. Unable to contact mother. Contacted sister who gave verbal permission for the evaluation." The Case Management Note dated 09/14/08 at 11:44 AM, documented "Contacted the skilled nursing facility, left verbal message to admissions." The facility Transfer/Discharge Summary form dated 09/16/08, documented the patient's right hand was blistered with open sores, IV infiltrate-gauze. (There was no documentation of a full thickness necrosis to the dorsal aspect of the patients right hand) The Physician Order dated 09/16/08 at 4:30 PM, indicated it was ok to transfer the patient. A skilled nursing facility facility letter dated 09/18/08, written by the Director of Nursing	S 154		

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S 154	Continued From page 10 indicated Patient #1 was transferred to a hospital for uncontrolled seizure activity. The patient was re-admitted to the skilled nursing facility from a hospital on 09/16/08 with a full thickness necrosis on the dorsal aspect of his right hand from chemical burns sustained at the hospital. On 03/31/09 at 1:00 PM, a telephonic interview was conducted with the (DON) Director of Nursing at a skilled nursing facility. The DON indicated Patient #1 was transferred back to the facility with a full thickness necrosis of the dorsal aspect of his right hand from chemical burns from an infiltrated IV while at the hospital. The DON indicated the transfer form from the hospital documented the patient's right hand as blistered with open sores. The DON indicated if the facility was aware of the severity of the patients hand wound she would not have accepted the patient transfer. The facility Case Management Discharge Planning Policy last revised 09/29/08, included under evaluation of the discharge plan: "The Case Manager and/or designee will conduct assessment and reassessment of the patient's condition to determine any modifications to the plan. The plan will be revised if necessary with all revisions reported to the patient, family and significant others with documentation recorded in the medical record." Under implementation of the discharge plan: "The Case Manager will arrange for any transfers to other facilities as needed. The patient, family or significant others will be informed of any changes and progress of the plan. The required documentation is completed." Severity: 2 Scope: 1	S 154		

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S 154	Continued From page 11 Complaint #NV00020260	S 154		
S 156 SS=D	NAC 449.332 Discharge Planning 14. If identified in a discharge plan, referral of a patient to outpatient services or transfer of the patient to another facility must be accomplished in a manner that meets the the identified needs of the patient, including the sharing of necessary medical information about the patient with the receiving service or facility. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to ensure that the transfer of a patient to another facility was accomplished in a manner that met the needs of the patient, including the sharing of necessary medical information about the patients condition with the receiving facility. (Patient #1) Findings include: The facility History and Physical dated 09/10/08, indicated the patient was a 32 year old male who was transferred to the facility from a nursing home for treatment of persistent seizure episodes. The patient's diagnoses included seizure disorder, possible sepsis, chronic respiratory failure, history of motor vehicle accident with head injury and subsequent encephalopathy, hypertension, and multiple decubitus ulcers with contractures. The Physician Admission Orders dated 09/10/08, included Dilantin 800 mg (milligrams) IVPB loading (intravenous piggy back) followed by Dilantin 100 mg IVPB every 8 hours. The Nursing Note dated 09/11/08 at 9:00 PM,	S 156		

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S 156	Continued From page 12 indicated the patient right arm IV line was discontinued. The patient's right arm was swollen with blisters on the hand and large blisters on the middle and right finger. The right thumb was purple and there were three draining blisters. The hand was elevated and the nurse called the pharmacist to discuss possible necrosis with Dilantin. The facility Risk Management Report dated 09/12/08 at 2:05 AM, indicated the nurse found the patients IV on the right hand had infiltrated while IV normal saline was running at 100 ml (milliliters) per hour. The nurse removed the Kerlix that was wrapped around the patients hand and found his hand was blistering; right thumb purplish, whole arm was swollen and bigger than the left arm. The patients pulse was palpable upon checking but the skin was cool to touch. The nurse called and notified the attending physician. No orders were given. Physician #2 came around 11:00 PM and assessed the patients arm. Physician orders were given for an MRI (magnetic resonance imaging) scan and if an MRI scan could not be done to do a CT (computerized tomography) scan of the patients arm and hand. A stat (immediate) x-ray was ordered. The right hand x-ray report dated 09/12/08 documented under findings: "Contracted flexed hand without fracture or dislocation. There is subchondral cyst along the base of the fifth metacarpal (finger). Soft tissue swelling seen along the hand dorsally. Moles or skin tags seen in the proximal to the wrist." The right forearm CT Scan report dated 09/12/08, indicated there was soft tissue edema seen within the distal right forearm, wrist and	S 156		

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S 156	Continued From page 13 dorsum of the right hand. The Physicians Progress Note dated 09/12/08, indicated the patients intravenous antibiotic Merrem infiltrated in the patient's right hand and wrist region causing swelling, erythema, soreness and blistering. The Physician Progress Note dated 09/12/08, documented possible contact dermatitis with blister formation to the patients right hand. The Physicians Progress Note dated 09/12/08, documented right hand blisters dorsal surface of the hand with questionable necrosis. The recommendation included a hand surgery consult regarding the patient's right hand. The Surgical Consultation Report by Physician #3 dated 09/12/08, indicated the patient had an intravenous medication infiltration in his right hand 35 to 48 hours ago. The patient was noted to have woody indurations of his arm and blister formation possibly from an intravenous infiltrate of Dilantin or Keppra medication. The patient had symptoms for 1 full day prior to the consultation. The patient was evaluated for compartment syndrome verses necrosis. The impression and plan indicated the patient did not have compartment syndrome. The physician after speaking to an infectious disease physician recommended local wound care to the blisters on the hand, necrosis on the dorsal aspect of the hand. The physician indicated surgical intervention would leave large open wounds which would not be able to be covered. The patient would be better off leaving the blisters and necrosis to heal without any full thickness exposure to the environment.	S 156		

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	NVS640HOS	A. BUILDING _____ B. WING _____	03/31/2009

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S 156	Continued From page 14 The Physician Hand Consult Note dated 09/12/08 at 8:30 PM, documented "No active compartment syndrome on physical exam, IV infiltrate-open necrosing tissue, local wound care, may need plastic surgery coverage if necrosis all dorsal skin..." The Physician Transfer Summary dated 09/15/08, indicated the patients discharge diagnoses included right upper extremity hand drug reaction with ischemic skin changes. During the patients hospitalization the patient developed a drug reaction likely caused by intravenous Dilantin or antibiotics that infiltrated. The patients IV line spilled over the skins tissue causing a blister formation on the right hand. The discharge medications orders included Silvadene 1% cream applied to areas of the right hand twice a day. The Physicians Progress Note dated 09/15/08, documented "Hand surgery notes reviewed, May need plastics here. Don't think SNF (skilled nursing facility) can care for iatrogenic (caused by a physician's treatment or procedure) wound there." The Physician Hand Consult Progress Note dated 09/15/08 at 12:30 PM, documented, "Hand inspection, dorsal wounds, blisters, decrease likely infiltrate with dorsal necrosis. Recommend local wound care per plastic surgery. No surgical intervention needed at this time." The Physicians Order dated 09/15/08, indicated wound care evaluation, Physician #7. WST (wound skin therapy) evaluate for wound care. Not suitable for TIF (transfer inter facility) The Nursing Note dated 09/15/08 at 2:00 PM,	S 156		

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S 156	Continued From page 15 documented " Note several small open ulcerations and 4 larger ulcerations on right hand/wrist area. Several blisters are still present. Note large amount of serosang DRNG. (drainage) Note moderate amount of blackened slough and necrotic tissue. Cleansed with normal saline soaked gauze. Applied Silvadene cream, then telfa, then wrapped with Kerlix." The Physician Order dated 09/16/08, documented respiratory stable for transfer inter facility if SNF (skilled nursing facility) was able to care for right hand. The Case Management Note dated 09/14/08 at 11:39 AM, documented "Received referral for re-evaluation for the skilled nursing facility. Patient unable to sign choice form. Unable to contact mother. Contacted sister who gave verbal permission for the evaluation." The Case Management Note dated 09/14/08 at 11:44 AM, documented "Contacted the skilled nursing facility, left verbal message to admissions." The facility Transfer/Discharge Summary form dated 09/16/08, documented the patient's right hand was blistered with open sores, IV infiltrate-gauze. (There was no documentation of a full thickness necrosis to the dorsal aspect of the patients right hand) The Physician Order dated 09/16/08 at 4:30 PM, indicated it was ok to transfer the patient. A skilled nursing facility facility letter dated 09/18/08, written by the Director of Nursing indicated Patient #1 was transferred to a hospital for uncontrolled seizure activity. The patient was	S 156		

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S 156	Continued From page 16 re-admitted to the skilled nursing facility from a hospital on 09/16/08 with a full thickness necrosis on the dorsal aspect of his right hand from chemical burns sustained at the hospital. On 03/31/09 at 1:00 PM, a telephonic interview was conducted with the (DON) Director of Nursing at a skilled nursing facility. The DON indicated Patient #1 was transferred back to the facility with a full thickness necrosis of the dorsal aspect of his right hand from chemical burns from an infiltrated IV while at the hospital. The DON indicated the transfer form from the hospital documented the patient's right hand as blistered with open sores. The DON indicated if the facility was aware of the severity of the patients hand wound she would not have accepted the patient transfer. The facility Case Management Discharge Planning Policy last revised 09/29/08, included under evaluation of the discharge plan: "The Case Manager and/or designee will conduct assessment and reassessment of the patient's condition to determine any modifications to the plan. The plan will be revised if necessary with all revisions reported to the patient, family and significant others with documentation recorded in the medical record." Under implementation of the discharge plan: "The Case Manager will arrange for any transfers to other facilities as needed. The patient, family or significant others will be informed of any changes and progress of the plan. The required documentation is completed." Severity: 2 Scope: 1 Complaint #NV00020260	S 156		

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S 298 SS=D	NAC 449.361 Nursing Service 9. A hospital shall ensure that its patients receive proper treatment and care provided by its nursing services in accordance with nationally recognized standards of practice and physicians' orders. This Regulation is not met as evidenced by: Based on record review the facility failed to ensure a patient received appropriate care by its nursing services in accordance with physician's orders. (Patient #3) Findings include: Patient #3 was admitted to the hospital on 9/18/09 for an elective laparoscopic assisted vaginal hysterectomy. According to the physician the surgery was uneventful. Post Operative orders included vital signs per recovery room routine, then every hour times 4, then every 4 hours if stable. Post-operatively the patient was transferred from the recovery room to the post operative floor at 2:30 PM on 9/18/08. Vital signs were performed on 9/18/08 at 2:30 PM and 7:04 PM. On 9/19/08 vital signs were done at 12:11 AM, 4:13 AM, 7:44 AM, 4:00 PM, 6:38 PM, and 11:15 PM. On 9/20/08 vital signs were done at 5:50 AM, 8:07 AM and 11:40 AM. Documentation from the patient record revealed that vital signs were not assessed per physician's order. There was no documentation of vital signs were done per physician order when the patient arrived on the post surgical unit. The vital signs were documented every 4 to 4 ½ hours on 9/18, every 2 ½ to 7 hours on 9/19. and every 2 ½ to 6	S 298		

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S 298	Continued From page 18 ½ hours on 9/20. Severity: 2 Scope: 1 Complaint #NV00019406 Severity: 2 Scope: 1	S 298		